Building an Effective State Exchange

The Patient Protection and Affordable Care Act (Affordable Care Act) requires the establishment of health insurance marketplaces, called "exchanges," in every state. Exchanges are designed to bring high-quality, easy-to-understand health coverage options to consumers. The law envisions that states will establish their own exchanges. However, the federal government will establish an exchange in any state that fails to do so.

The Affordable Care Act includes standards that all exchanges must meet. However, the law also leaves a great deal of flexibility and work to the states when it comes to the design and implementation of health insurance exchanges that meet these standards. Therefore, the ability of exchanges to function as marketplaces for high-value coverage—marketplaces that are user-friendly, transparent, and stable—largely depends on the policy choices made by states.

To help states and consumer advocates evaluate these policy options, Families USA has produced the attached benchmarks. These benchmarks can serve as a starting point for the exchange design process. For example, a legislative committee or a consumer coalition could use the benchmarks to identify common objectives to advocate for in the exchange implementation process. Eventually, the benchmarks can also be used to assess the design of a state's exchange, to see how well it can meet the goal of providing a consumer-friendly marketplace for coverage.

You should feel free to adapt and use these benchmarks in whatever way is most helpful, including reproducing them for your own purposes. We encourage you to tweak the language or omit some of the benchmarks—whatever is necessary to make this piece work for you. You do not need to attribute this document to Families USA (unless that would be helpful to you), and you are also welcome to use your own logo and layout in any reproductions.

Once you've decided on benchmarks for exchange design, you will need to operationalize them. There's no "one size fits all" strategy for operationalizing the benchmarks: The best way to do that will vary from state to state. If Families USA staff can be helpful to you as you seek to put flesh on these bones, you should feel free to contact us at stateinfo@familiesusa.org.

For more information, see *Implementing Health Insurance Exchanges: A Guide to State Activities and Choices*, available online at http://familiesusa2.org/assets/pdfs/health-reform/Guide-to-Exchanges.pdf.

Benchmarks for Building an Effective State Exchange

1. Exchange planning, implementation, and governance should all function transparently and should be receptive to public input.

2. The governing body of the exchange should include consumer representatives as official members. The governing body should not include members who may have conflicts of interest due to affiliations with health care industries.

3. The exchange operating entity should be subject to state laws regarding transparency and public input for decision-making bodies, along with other measures that seek to ensure the accountability and integrity of the entity.

4. As required by the Affordable Care Act, consumers must be able to go to a single website and use one application to find out whether they and their family members are eligible for premium credits, Medicaid, or the Children's Health Insurance Program (CHIP), and then to easily enroll in coverage. Consumers should be able to apply for coverage (and to be assisted in doing so) at community health centers, grocery stores, churches, fairs, and other community locations. Under the Affordable Care Act, states must also, to the greatest extent possible, use existing federal and state sources of income and other information rather than requiring people to submit all new documentation when they apply for coverage.

5. The exchange should be designed to meet the particular needs of individuals who, due to fluctuations in income, "transition" between public coverage programs like Medicaid and private coverage through the exchange. To help minimize changes in coverage, people should be eligible for Medicaid and CHIP for 12 months at a time.

6. "Navigators"—created by the Affordable Care Act to help consumers and employers learn about, and enroll in, coverage options—should be selected based on their ability to put consumer and employer interests first, without conflicts of interest. In accordance with the law, Navigators specifically must exhibit qualities and expertise that would allow them to serve uninsured and underinsured consumers well.

7. The state should take an active role in making sure that only health plans that provide good value to consumers are permitted to sell coverage through the exchange. Factors that indicate "good value" could include scoring well on quality indicators and having provider networks that meet enrollees' needs, while charging reasonable premiums and demonstrating a history of seeking only reasonable rate increases.

8. The state should take an active role in ensuring that the mix of health plans offered in the exchange promotes good decision-making among residents about which plans will best meet their needs. The state should make sure that residents are not overwhelmed by a bewildering number of plan options that cannot be easily compared. The state may want to further standardize

plan options beyond the tiers required in the Affordable Care Act, such as by limiting the number of different deductible and cost-sharing combinations sold at each tier.

9. The state should ensure that coverage for needed services currently required under state benefit mandates is provided in exchange plans.

10. The state should enact policies to prevent adverse selection and to ensure the stability of the exchange. The state should require insurance plans sold outside the exchange to comply with all of the same consumer protection requirements that health plans inside the exchange must meet. The state can also take measures to ensure that plans outside the exchange aren't operating just to attract the lowest cost, healthiest enrollees. For example, like insurers inside the exchange, insurers operating outside should be required to sell at least one silver level plan and one gold level plan. The state should also make sure that brokers do not have incentives, such as higher commissions, to steer residents into coverage outside the exchange.

11. The Affordable Care Act leaves several decisions up to the state regarding the group insurance market: whether to combine the small group and individual markets, whether to define a small employer as a firm with up to 100 workers or up to 50 workers until 2016, and whether to allow large employers to obtain coverage through the exchange in 2017. These decisions should be made based on analyses determining which options would provide the most accessible and affordable health coverage options for consumers.

12. Exchange features should be tested with diverse consumers before their implementation. After exchange implementation, a formal feedback loop should be available to consumers and their representatives so that any problems with exchange functioning can be reported and addressed.

13. The exchange should provide appropriate language services to meet the needs of individuals who do not speak English or who have limited-English proficiency.

14. The state may currently fund health coverage or other programs that it will no longer need to finance in the future due to provisions of the Affordable Care Act, such as premium tax credits. If savings result from the elimination of such state-funded programs, the state should seek to invest that money in efforts to ensure that lower income families fare well in the health coverage system. For example, the state could use such savings to provide further premium or cost-sharing assistance to low-income residents or to cover benefits that aren't included in exchange plans.

15. Any consideration of participation in a regional or interstate exchange must take into account the potential effects on the state's existing consumer protections and regulatory authorities. In addition, coordination issues with Medicaid, CHIP, and other state coverage programs should be carefully examined to ensure that consumer safeguards and access to coverage would not be diminished in a regional or interstate exchange.